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CIRCULAR LETTER.(unnumbered).

VENEREAL DISEASE

1. Treatment. In accordance with provisions of War Department TB MED 96 and 106, 1944, penicillin will be the drug of choice in treatment of gonorrhea and syphilis.

a. Gonorrhea. (1) Treatment may be carried out by a unit surgeon, dispensary or hospital. Four (4) intramuscular injections of 25,000 units are given every 2 hours, totalling 100,000 units; this will necessitate the patient remaining in the dispensary for 6 hours. On completion of above treatment patient will be directed to return to the place of treatment on the following 2 mornings for the purpose of tests for cure. On final discharge from place of treatment patient will be referred back to the unit surgeon who will examine the patient once weekly for a period of 3 weeks. This examination will consist of examination for evidence of discharge and microscopic examination of urine. In a small proportion of cases a light mucoid discharge persists for a week or two following treatment. This discharge is unimportant in the absence of positive smear.

(2) Patients in whom a favorable response is not evident by the third posttreatment day should be retreated according to the schedule in paragraph 1 a (1). Patients not responding to the second course should be given a prolonged and intensive third course of penicillin, totalling at least 300,000 units. Individuals failing to respond to the third course should be treated with sulfadiazine or sulfathiazol.

(3) Patients who have received penicillin therapy for gonorrhea will also have monthl serological tests for syphilis for six months.

b. Syphilis. (1) Penicillin will be used in the following types of syphilis:

(a) Untreated primary and secondary syphilis (Mapharsen/bismuth treatment has not been initiated).

(b) Untreated latent syphilis.

(c) Treated primary and secondary syphilis which has failed to respond to Mapharsen/bismuth therapy.

(d) Treated primary, secondary and latent syphilis intolerant or sensitive to Mapharsen/bismuth. This group includes serious reaction to arsenic such as: jaundice, exfoliative dermatitis, blood dyscrasia and encephelopathy.

(2) Technique. Penicillin therapy of syphilis requires hospitalization for about 10 days. Total dosage will be 2,400,000 units of penicillin given in 60 consecutive intramuscular injections of 40,000 units at 3 hour intervals day and night for 7 1/2 days. No additional anti-syphilitic therapy is to be given during or after completion of this course except in the case of penicillin failure. Treatment should continue without interruption once it is started.

(3) Post-treatment Observation. Cases of syphilis treated with penicillin will have monthly inspections and quantitative serological tests for syphilis for a period of 12 months. Medical officers should request serological tests for syphilis as authorized and described in TM 8-227. Results of the tests should be reported in units. In primary and secondary syphilis, spinal fluid will be examined as soon after completion

of six months' observation as feasible. Syphilis Register may not be closed until this examination has been accomplished. Cell count and Pandy or Nonne-Apelt should be performed within 30 minutes of withdrawal of the spinal fluid in a local laboratory. Syphilis Register (WD AGO 8-114, formerly WD MD 78) will be prepared in the usual manner with a brief note outlining the treatment procedure. Notation will be made in the Register that the patient is to be managed in accordance with TB MED 106, 1944. WD MD Form 78a (Patient's Record of Syphilis Treatment) will be prepared. A brief account of the treatment as prescribed above will be entered. An additional statement will be made to the effect that no further treatment is required except in the event of a clinical or serological relapse. Patient will have regular monthly physical examination and blood tests. On completion of the treatment, record is to be transmitted to The Surgeon General after 12 months observation showing that the patient has remained serologically negative and has shown no evidence of clinical relapse. In latent syphilis, Syphilis Register will be transmitted to The Surgeon General after 12 months of observation if there has been no serological relapse. Serum fastness will not be uncommon in cases of latent syphilis on penicillin therapy.

(4) Management of Penicillin Failures. All forms of treatment failure after 2,400,000 units of penicillin will receive a second course of the drug. This will consist of 4 million units of penicillin given in 80 consecutive intramuscular injections of 50,000 units at 3 hours intervals day and night for 10 days. Cases of treatment failure after the second course of penicillin will be transferred to a hospital [illegible], designated in each base, for further evaluation and treatment.

c. Chancroid. (1) This venereal disease is also prevalent in the Philippines. The streptobacillus of Ducrey causes a punched out purulent ulcer, which develops 3 to 7 days following sexual exposure. These lesions are important because of "mixed infections", i.e., chancroidal infection and syphilis

may both be present. In such cases the clinical picture of chancroid predominates. Even though syphilis may be present, dark field examinations are usually negative. In about 40% of chancroidal infections primary syphilis is also eventually demonstrated. The bacillus of Ducrey is extremely difficult to demonstrate in the laboratory. If the smears are negative, but the clinical appearance is that of chancroid, the diagnosis "Chancroid (based upon clinical symptomatology)" should be entered upon the patient's records and included in venereal disease reports.

(2) Management of chancroidal infections and other penile lesions. All penile lesions should have a serological examination and at least three (3) daily dark field examinations. If dark field examinations are negative, lesions may then be treated by local measures and/or with sulfathiazol, 2 gm. daily, by mouth. Local use of penicillin, though it results in healing, is definitely contraindicated in the treatment of penile lesions since it may interfere with later diagnosis of syphilis. All such cases require following with monthly serological examinations for syphilis by the unit surgeon for at least three (3) months.

d. Lymphopathia venereum requires hospitalization in a general hospital.

e. Granuloma inguinale requires hospitalization in a general hospital.

2. Line of Duty. Common designations for line of duty for venereal disease in accordance with War Department Circular No. 458, 1944 are as follows:

a. "LD: No, EPTS" - if venereal disease was contracted prior to entrance into the service, and not aggravated by the service.

b. "LD: No, Misconduct" - if venereal disease is contracted and individual does not report for and receive treatment as prescribed in Army Regulations, and then only if treatment is given on a duty status.

c. "LD: No, AW 107" - (for enlisted personnel only) if venereal disease is acquired and individual does not report for and receive treatment as prescribed in Army Regulations and loses more than one day from duty either in

hospital or quarters.

d. "LD: No."

(1) Enlisted men - if venereal disease is contracted while individual is absent from duty without official permission.

(2) Officers - if venereal disease is contracted and officer does not report for and receive treatment, as prescribed in Army Regulations, or if venereal disease is contracted while officer is absent from duty without official permission.

e. "LD: Yes" - if venereal disease is contracted while individual is on duty status or absent with authority and if he or she reports for and receives treatment in accordance with Army Regulations.

3. Education and Propaganda. a. Publicity regarding the effectiveness of penicillin in the treatment of venerea infections is considered a factor in general relaxation of precautions. Drastic measures in venereal disease control are necessary to curb the rapidly rising rate among troops stationed in the Philippines. In accordance with the provisions of AR 40-210 and USAFFE Regulations No. 50-55, intensive venereal disease education is the responsibility of unit surgeons. Attention should be directed particularly to:

(1) High venereal disease rate in the civil population.

(2) Superiority of mechanical prophylactics.

(3) The fact that penicillin is not a sure cure.

(4) The use of films, pamphlets and posters.

(5) Availability of prophylactics.

(6) Establishment, and circulation of information, as to location of prophylactic stations.

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